7.c. Medical supplies, equipment and appliances suitable for use in the home. (continued)

Prior authorization must be obtained for all augmentative and alternative communication devices.

Coverage of **augmentative and alternative communication devices** is limited to:

1) Evaluation for use of augmentative and alternative communication devices to supplement oral speech.

2) Speech pathologists may only provide modification and programming of augmentative and alternative communication devices.

3) Construction, programming or adaptation of augmentative and alternative communication devices.

Augmentative and alternative communication devices are not covered if facilitated communication is required in addition to the devices.

- The following medical supplies and equipment are not eligible for payment:

1) Medical supplies and equipment that are not covered under Medicare except for raised toilet seats; bathtub chairs and seats; bath lifts; prosthetic communication devices; and any item determined by prevailing community standards or customary practice to be an appropriate and effective medical necessity ~~which~~ that meets quality and timeliness standards as the most cost effective medical supply or equipment available for the medical needs of the recipient and represents an effective and appropriate use of medical assistance funds, is within the specified service limits of the Medical Assistance program, and is personally furnished by a provider.

2) Routine, periodic maintenance on medical equipment owned by a long-term care facility or hospital when the cost of maintenance is billed to medical assistance on a separate claim for payment.

8. Private duty nursing services.

- Private duty nursing services are only covered when medically necessary, ordered in writing by the physician, and documented in a written plan of care that is reviewed and revised as medically necessary by the physician at least once every 62 days.

- ~~Except for the services identified in an Individualized Education Plan under item 13.d., private~~ Private duty nursing services are not reimbursable if an enrolled home health agency is available and can adequately provide the specified level of care, or if a personal care assistant can be utilized.

- Private duty nursing services includes extended hour nursing services provided by licensed registered nurses or licensed practical nurses employed by a Medicare-certified home health agency or self-employed.

- Department prior authorization is required for all private duty nursing services. Prior authorization is based on medical necessity; physician's orders; the recipient's needs, diagnosis, and condition; an assessment of the recipient; the plan of care; and cost-effectiveness when compared to alternative care options. For recipients who meet hospital admission criteria, the Department shall not authorize more than 16 hours per day of private duty nursing service or up to 24 hours per day of private duty nursing service while a determination of eligibility is made for recipients who are applying for services under Minnesota's approved model home and community-based services waiver or during an appeal to the appropriate regulatory agency to determine if a health benefit plan is required to pay for medically necessary nursing services. For recipients who do not meet hospital admission criteria, the Department may authorize up to 9.75 hours per day of private duty nursing service.

- Authorized units of private duty nursing service may be used in the recipient's home or outside of the recipient's home if normal life activities take the recipient outside of their home and without private duty nursing service their health and safety would be jeopardized. To receive private duty nursing services at school, the recipient or his or her responsible

8. Private duty nursing services. (continued)

party must provide written authorization in the recipient's care plan identifying the chosen provider and the daily amount of services to be used at school.

- Private duty nursing providers that are not Medicare certified must refer and document the referral of dual eligibles to Medicare providers when Medicare is the appropriate payer.

- Recipients may receive shared private duty nursing services, defined as nursing services provided by a private duty nurse to two recipients at the same time and in the same setting. Decisions on the selection of recipients to share private duty nursing services must be based on the ages of the recipients, compatibility, and coordination of their care needs. For purposes of this item, "setting" means the home or foster care home of one of the recipients, a child care program that is licensed by the state or is operated by a local school district or private school, or an adult day care that is licensed by the state.

  The provider must offer the recipient or responsible party the option of shared care. If accepted, the recipient or responsible party may withdraw participation at any time.

  The private duty nursing agency must document the following in the health service record for each recipient sharing care:

  a) authorization by the recipient or responsible party for the maximum number of shared care hours per week chosen by the recipient;

  b) authorization by the recipient or responsible party for shared service provided outside the recipient's home;

  c) authorization by the recipient or responsible party for others to receive shared care in the recipient's home;

8. Private duty nursing services. (continued)

d) revocation by the recipient or responsible party of the shared care authorization, or the shared care to be provided to others in the recipient's home, or the shared care to be provided outside the recipient's home; and

e) daily documentation of the shared care provided by each private duty nurse including:

1) the names of each recipient receiving shared care together;

2) the setting for the shared care, including the starting and ending times that the recipients received shared care; and

3) notes by the private duty nurse regarding changes in the recipient's condition, problems that may arise from the sharing of care, and scheduling and care issues.

In order to receive shared care:

a) the recipient or responsible party and the recipient's physician, in conjunction with the home health care agency, must determine:

1) whether shared care is an appropriate option based on the individual needs and preferences of the recipient; and

2) the amount of shared care authorized as part of the overall authorization of private duty nursing services;

b) the recipient or responsible party, in conjunction with the private duty nursing agency, must approve the setting, grouping, and arrangement of shared care based on the individual needs and preferences of the recipients;

c) the recipient or responsible party, and the private duty nurse, must consider and document in the recipient's health service record:

8. Private duty nursing services. (continued)

1) the additional training needed by the private duty nurse to provide care to two recipients in the same setting and to ensure that the needs of the recipients are appropriately and safely met;

2) the setting in which the shared private duty nursing care will be provided;

3) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting;

4) a contingency plan that accounts for absence of the recipient in a shared care setting due to illness or other circumstances. The private duty nurse will not be paid if the recipient is absent;

5) staffing backup contingencies in the event of employee illness or absence;

6) arrangements for additional assistance to respond to urgent or emergency care needs of recipients.

- The following services are not covered under medical assistance as private duty nursing services:

a) private duty nursing services provided by a licensed registered nurse or licensed practical nurse who is the recipient's spouse, legal guardian, or parent of a minor child or foster care provider of a recipient who is under age 18;

b) private duty nursing services that are the responsibility of the foster care provider;

c) private duty nursing services when the number of foster care residents is greater than four;

8. Private duty nursing services. (continued)

d) private duty nursing services when ~~combined with home health services, personal care services, and foster care payments, less the base rate, that exceed the total amount that public funds would pay for the recipient's care in a medical institution (This is a utilization control limitation conducted on a case-by-case basis in order to provide the recipient with the most~~ other, more cost-effective, medically appropriate services are available~~.)~~; ~~or~~ and

e) private duty nursing services provided to a resident of a hospital, nursing facility, intermediate care facility, or a licensed health care facility.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist).

Coverage of **speech and language therapy services** is limited to:

(1) Services provided upon written referral by a physician, physician assistant or nurse practitioner or in the case of a resident of a long-term care facility on the written order of a physician as required by 42 CFR §483.45.

(2) Services provided by a speech language pathologist or a person completing the clinical fellowship year required for certification as a speech-language pathologist under the supervision of a speech-language pathologist.

(3) (A) Services provided to a recipient whose functional status is expected by the physician, physician assistant or nurse practitioner to progress toward or achieve the objectives in the recipient's plan of care within a 60-day period; or

(B) Specialized maintenance therapy services necessary for maintaining the patient's current level of functioning or for preventing deterioration of the patient's medical condition(s).

(4) For long term care recipients, services for which there is a statement in the clinical record every 30 days that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. This statement is not required for an initial evaluation.

(5) Services specified in a plan of care that is reviewed and revised as medically necessary by the recipient's attending physician, physician assistant or nurse practitioner at least once every 60 days. If the service is a Medicare covered service and the recipient is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare and the recipient must be visited by the physician or the physician's delegate as required by Medicare.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Speech-language pathologist is defined as a person who has a certificate of clinical competence in speech-language pathologies from the American Speech-Language-Hearing Association and meets the state licensure and registration requirements for the services the person provides.

Coverage of **speech-language therapy services** does *not* include:

(1) Services that are not documented in the recipient's health care record.
(2) Services by more than one provider of the same type for the same diagnosis unless the service is provided by a school district as specified in the recipient's individualized education plan.
(3) Services that are denied Medicare payment because of the provider's failure to comply with Medicare requirements.
(4) Services that are provided without written referral.
(5) Services not medically necessary.
(6) Services that are not part of the recipient's plan of care.
(7) Services provided in a nursing facility, ICF/MR or day training and habilitation services center if the cost of speech-language pathology has been included in the facility's per diem.
(8) Services provided by a speech-language pathologist other than the pathologist billing for the service, or a person completing the clinical fellowship year under the supervision of the pathologist, unless the pathologist provided the service as an employee of a rehabilitation agency, long-term care facility, outpatient hospital, clinic, or physician; in which case, the agency, facility or physician must bill for the service.
(9) Services provided by an independently enrolled speech language pathologist who does not maintain an office at his or her own expense.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Coverage of **hearing (audiology) therapy services** is limited to:

(1) Services provided upon written referral by a physician, physician assistant or nurse practitioner.
(2) Services provided by an independently enrolled audiologist who maintains an office at their own expense or an audiologist who is employed by and providing audiology services in a hospital, rehabilitation agency, home health agency, or clinic.
(3) Services provided to a recipient who is expected to progress toward or achieve the objective specified in their plan of care within a 60-day period.
(4) Services provided under a written treatment plan which is reviewed at least once every 60 days, with certification and recertification by the ordering physician or physician assistant. If the service is provided to a Medicare beneficiary and covered by Medicare, the physician or physician delegate must review the plan of care and visit the patient at intervals required by Medicare rather than at intervals required by MA.
(5) For long term care recipients, services for which there is a statement in the clinical record every 30 days by the audiologist providing or supervising the services that the nature, scope, duration, and intensity of the services provided are appropriate to the medical condition of the recipient. (This statement is not required for an initial evaluation).
(6) Services provided in the independent audiologist's own office, recipient's home, nursing facility, ICF/MR, or day training and habilitation services site.

Audiologist is defined as an individual who has a certificate of clinical competence from the American Speech-Language-Hearing Association and meets the state licensure and registration requirements for the services the person provides.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Coverage of **hearing (audiology) therapy services** does *not* include:

(1) Services that are not documented in the recipient's clinical record, even if the services were authorized by a physician.
(2) Training or consultation provided by an audiologist to an agency, facility, or other institution.
(3) Services provided by an audiologist other than the audiologist billing for the services, or a person completing the clinical fellowship year under the supervision of the audiologist, unless the audiologist provided the services in a hospital, rehabilitation agency, home health agency, or clinic, or as an employee of a physician or long-term care facility; in which case the contracting or employing facility, agency, or person must bill for the services.

Hearing aid services: After a physician rules out medical and surgical contraindications, the physician refers the recipient for an audiologic evaluation. An audiologist or otolaryngologist provides audiologic testing, and if a hearing aid is indicated, prescribes a specific hearing aid offered under the hearing aid volume purchase contract or refers the recipient to a hearing aid services provider.

Payment is made to hearing aid services providers for hearing aids, dispensing fees, hearing aid repairs, accessories, ear molds when not provided with the hearing aid and batteries.

Coverage of **hearing aids** is limited to:

(1) One monaural or one set of binaural hearing aids within a period of five years unless prior authorized. A hearing aid will not be replaced when the recipient has received a replacement hearing aid twice within the five year period previous to the date of the request.
(2) Non-contract hearing aids require prior authorization.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

Coverage of **hearing aids** does *not* include:

(1) Replacement batteries provided on a scheduled basis regardless of their actual need.
(2) Services specified as part of the contract price when billed on a separate claim for payment. This includes any charges for repair of hearing aids under warranty.
(3) Routine screening of individuals or groups for identification of hearing problems.
(4) Separate reimbursement for postage, handling, taxes, mileage, or pick-up and delivery.
(5) Nonelectronic hearing aids, telephone amplifiers, vibrating molds, dry aid kits, and battery chargers.
(6) Maintenance, cleaning, and checking of hearing aids, unless there has been a request or referral for the service by the person who owns the hearing aid, the person's family, guardian or attending physician.
(7) Loaner hearing aid charges.
(8) Canal type hearing aids.
(9) A noncontract hearing aid that is obtained without prior authorization.
(10) Services included in the dispensing fee when billed on a separate claim for payment.
(11) Hearing aid services to a resident of a long-term care facility if the services did not result from a request by the resident, a referral by a registered nurse or licensed practical nurse who is employed by the long-term care facility, or a referral by the resident's family, guardian or attending physician.
(12) Hearing aid services prescribed or ordered by a physician if the physician or entity commits a felony listed in United States Code, title 42, section 1320a-7b, subject to the "safe harbor" exceptions listed in 42 CFR 1001.952.
(13) Replacement of a lost, stolen or damaged hearing aid if MA has provided three hearing aids in the five years prior to the date of the request for a replacement.

11.c. Speech, language, and hearing therapy services (provided by or under the supervision of a speech pathologist or audiologist). (continued)

~~**Augmentative and alternative communication devices** are defined as devices dedicated to transmitting or producing messages or symbols in a manner that compensates for the impairment and disability of a recipient with severe expressive communication disorders. Examples include: communication picture books, communication charts and boards, and mechanical or electronic dedicated devices. Prior authorization must be obtained for all augmentative communication devices.~~

~~Coverage of **augmentative and alternative communication devices** is limited to:~~

~~(1) Evaluation for use of augmentative and alternative communication devices to supplement oral speech.~~
~~(2) Speech pathologists may only provide modification and programming of augmentative and alternative communication devices.~~
~~(3) Construction, programming or adaptation of augmentative and alternative communication devices.~~

~~**Augmentative and alternative communication devices** are not covered if facilitated communication is required.~~

26. Personal care services.

Personal care services are provided by personal care provider organizations or by use of the PCA Choice option.

A. Personal care provider organizations

Personal care services provider qualifications:

- Personal care assistants must be employees of or under contract with a personal care provider organization within the service area. If there are not two personal care provider organizations within the service area, the Department may waive this requirement. If there is no personal care provider organization within the service area, the personal care assistant must be enrolled as a personal care provider.

- If a recipient's diagnosis or condition changes, requiring a level of care beyond that which can be provided by a personal care provider, non-Medicare certified personal care providers must refer and document the referral of dual eligibles to Medicare providers (when Medicare is the appropriate payer).

- Effective July 1, 1996, personal care assistant means a person who:

  a) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

  b) is able to effectively communicate with the recipient and the personal care provider organization;

  c) is able to and provides covered personal care services according to the recipient's plan of care, responds appropriately to the recipient's needs, and reports changes in the recipient's conditions to the supervising

26. Personal care services. (continued)

qualified professional. For the purposes of this item, "qualified professional" means a registered nurse or a mental health professional defined in item 6.d.A. of this attachment;

d) is not a consumer of personal care services; and

e) is subject to criminal background checks and procedures specified in the state human services licensing act.

- Effective July 1, 1996, personal care provider organization means an entity enrolled to provide personal care services under medical assistance that complies with the following:

a) owners who have a five percent interest or more, and managerial officials are subject to a background study. This applies to currently enrolled personal care provider organizations and those entities seeking to enroll as a personal care provider organization. Effective November 10, 1997, an organization is barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in the state human services licensing act, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in the state human services licensing act;

b) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provide proof thereof. The insurer must notify the Department of the cancellation or lapse of policy; and

26. Personal care services. (continued)

c) the organization must maintain documentation of personal care services as specified in rule, as well as evidence of compliance with personal care assistant training requirements.

B. PCA Choice option

Under this option, the recipient and qualified professional do not require professional delegation.

- The recipient or responsible party:

a) uses a PCA Choice provider, not a personal care provider organization. A PCA Choice provider assists the recipient to account for covered personal care assistant services. A PCA Choice provider is considered a joint employer of the qualified professional described in item A and the personal care assistant, and may not be related to the recipient, qualified professional, or personal care assistant. A PCA Choice provider or owner of the entity providing PCA Choice services must pass a criminal background check according to the state human services licensing act;

b) uses a qualified professional for help in developing and revising a plan to meet the recipient's assessed needs and for help in supervising the personal care assistant services, as recommended by a public health nurse;

c) supervises the personal care assistant if there is no qualified professional;

d) with the PCA Choice provider, hires and terminates the qualified professional;

e) with the PCA Choice provider, hires and terminates the personal care assistant;

26. Personal care services. (continued)

f) orients and trains the personal care assistant in areas that do not require professional delegation as determined by the county public health nurse;

g) supervises and evaluates the personal care assistant in areas that do not require professional delegation as determined in the assessment;

h) cooperates with the qualified professional and implements recommendations pertaining to the health and safety of the recipient;

i) with the PCA Choice provider, hires a qualified professional to train and supervise the performance of delegated tasks done by the personal case assistant;

j) monitors services and verifies in writing the hours worked by the personal care assistant and the qualified professional;

k) develops and revises a care plan with assistance from the qualified professional;

l) verifies and documents the credentials of the qualified professional; and

m) together with the PCA Choice provider, qualified professional, and personal care assistant, enters into a written agreement, before services begin. The agreement must include:

1) the duties of the recipient, PCA Choice provider, qualified professional, and personal care assistant;

2) the salary and benefits for the qualified professional and personal care assistant;